ERWIN I	HEALTH CARE CENTER	100 STALLING LANE ERWIN, TN 37650						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE					
F 000	INITIAL COMMENTS	F 000						
	An annual recertification survey and complaint investigation #27546, #27173, & #27355, were completed on May 11, 2011, at Erwin Health Care Center. No deficiencies were cited related to complaint investigation #27355. Deficiencies were cited related to complaint investigation #27546 and #27173 under 42 CFR PART 482, Requirements for Long Term Care Facilities. 483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	Resident # I- Privacy will be maintained at all times for resident # I when wound care is being provided. Personal privacy will be maintained for all residents in the facility when personal care or treatments are being administered by nursing personnel. Policies and Procedures relating to maintaining privacy for residents will be reviewed on 5/20/11 with revisions made if appropriate. An In-service will be completed by the DON on 5/23/11 for all nursing staff relating to the policy and procedure for maintaining privacy at all times for our residents. An In-service will be held on 5/26/11 for those who are unable to attend on 5/23/11. Audits will be completed by the Quality Assurance Nurse on five residents o a daily basis for the first two weeks beginning 5/23/11, then five residents will be reviewed weekly for four weeks and monthly thereafter. The audits will be reviewed by the QA Committee on a monthly basis. The Quality Assurance Committee members include the Administrator, Assistant to the Administrator, Medical Director, Pharmacist, Registered Dietitian, MDS Coordinator, Rehab Director, Social Service Director, and QA Nurse. When areas of focus and trends are Identified, action plans will be developed and follow up will be completed.					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evallable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Morin Tata.

(X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			TRUCTION	(X3) DATE SU COMPLE	
			445291	B. WIN	iG			05/11	/2011
140	ROVIDER OR SUPPLIER	ÉR			10	00 STALL	RESS, CITY, STATE, ZIP CODE ING LANE N 37650		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	/ MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG		(E ÇRC	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 164	contract; or the res	lder	it.	F.	164				
so	by: Based on medical	rec acil r or							
	The findings includ	ed:	9						
	2010, with diagnos	es i nia	tted to the facility June 24, ncluding Fractured Hip Dysphagia, Parkinson's a.						
	room on May 10, 2	011 lurs olino							
	p.m., on the patlo,	con clos	on May 10, 2011, at 12:30 firmed the RN failed to ing the blinds in the wound care.						
F 252 \$S=D	SAFE/CLEAN/COMENVIRONMENT The facility must promfortable and he	ovlo	PRTABLE/HOMELIKE de a safe, clean, like environment, allowing or her personal belongings	F:	252	cleaned 5/13/11 debris a All toile Sticks of	owls in rooms 107, 109, 113, and with Scouring Sticks on 5/12/11 with positive results. The brown/re no longer in the bowel thouse with Scoun a consistent basis by environment	and black oring ental	6/20
	to the extent possil	ole.	or tret hetaorigi neioriâniâa			bowel. A	el when any stained debris is not all toilet bowls are eleaned with a BC on a dally basis.	omet	

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STATEM	ENT OF DEFICIENCIES	(V4) PDOV//DEE/201990159151	_ , _		OIVIB IVE	<i>J.</i> 0938-0391
AND PL	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		445291	B. Wit	NG	- 05/	11/2011
NAMEC	F PROVIDER OR SUPPLIER			STREET ADDRESS SIDE STATE		11/2011
ERWI	N HEALTH CARE CENTE	ĒR		STREET ADDRESS, CITY, STATE. 100 STALLING LANE ERWIN, TN 37650	ZIP CODE	
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 25	This REQUIREMENty: Based on observation failed to provide a column to facility's resident to facility's secured union. The findings included Observation during that 9:55 a.m., revealed resident rooms #'s 10 build-up of brown del Observation on May revealed the toilet bots same brown debris.	on and interview the facility ean environment in four of bathrooms observed on the t. d: the initial tour on May 9, 2011 d four bathrooms located in 07, 109, 113, and 117 had a bris inside the toilet bowls. 10, 2011, at 7:45 a.m., wis were still soiled with the usekeeping Supervisor, on		Policies and procedures rela bowls will be reviewed on 5/2 appropriate. In-services will be completed Environmental Staff by the I Environmental Services on 5. appropriate policy and procedure Scouring Stick. An In-ser completed on 5/26/11 for those to attend on 5/23/11. Audits will be completed on first four weeks begin monthly thereafter. The Qual Nurse will complete these and determine if there is any build debris in the toilet bowls. The audit will be reviewed by on a monthly basis. The Quali Committee members include the Administrator, Medical D. Pharmacist, Registered Dietiti Coordinator, Rehab Director, Director, and QA Nurse.	for the Director of (23/11 relating to the dures for utilizing vices will be see who were unable vive rooms each week ning 5/23/11 and ity Assurance lits. The audits will l up of brown the QA Committee ity Assurance trator, Assistant to lirector, an. MDS	
F 281 SS=D	resident room #'s 107 confirmed the toilet be the bathrooms were of with a cleaning product brown debris from the 483.20(k)(3)(i) SERVI- PROFESSIONAL STA The services provided must meet professional This REQUIREMENT by: Based on medical recithe facility failed to obta	15 p.m., on the secure unit in 17, 109, 113, and 117, 109, 113, and 117, 109 per semained soiled after leaned by housekeeping of that failed to remove the toilets. CES PROVIDED MEET ANDARDS or arranged by the facility all standards of quality. is not met as evidenced ord review and interview	F 281	When areas of focus and trend action plans will be developed be completed.	rom this facility y ordered by the cried out and the a timely manner. d orders carried to the facility	6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING _	STRUCTION	(X3) DATE	SURVEY LETED
		445291	B. WING	-		05/	11/2011
ERWIN	PROVIDER OR SUPPLIER HEALTH CARE CENTE	sano i	s	100 STAL	RESS, CITY, STATE, ZIP CODE LING LANE TN 37650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CR	PROVIDER'S PLAN OF CORRE- EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	treatment of a fractive twenty-eight resident twenty-eight resident. The findings include Resident #28 was a December 31, 2009 Dementia with Behar Cellulitis. Medical record reviee (MDS) revealed the thinking, was unstead and required assistate activities of daily living Medical record reviee November 20, 2010, observed sitting in the inroomPt denies with R.O.M. (range of mental status" Medical record review revealed no document November 20, 2011, any complaints of pair November 20, 2011. Medical record review November 24, 2010, "resident with s/sx (pain in (R)(right) hip weight X-ray of (R)	are for one resident (#28) of alts reviewed. ad: dmilted to the facility , with diagnoses including vior Disturbances and w of the Minimum Data Set resident had disorganized dy, wheel chair dependent, nce of one person with log. w of a nurse's note dated at 4:00 a.m., revealed "pt e floor onbuttocks pain and has no problems if motion)(no) change in w of the nurses' notes need entries between and November 24, 2010, of in or bruising from the fall on or of a nurse's note dated at 5:00 a.m., revealed signs and symptoms) of with ROMUnable to bear hip ordered" y of Pain Assessment Medication Administration	F 28	RN's complification of the service who we have a service who we have a service who we have a service when ser	dit will be reviewed by the QA (onthly basis. The Quality Assura ittee members include the Admin nt to the istrator, Medical Director, Phari red Dictitian, MDS Coordinator or, Social Service Director, and Q areas of focus and trends are idea plans will be developed and folto	e inted An In- r those is on all x- will be urse. The begin on Contmittee ince istrator, macist, Rehab la Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	TRUCTION	(X3) DATE SURVEY		
		445291	B. WING			_05/	11/2011	
CONTRACTOR CONTRACTOR	NAME OF PROVIDER OR SUPPLIER ERWIN HEALTH CARE CENTER				ESS, CITY, STATE, ZIP CODE NG LANE N 37650			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	the resident exhibited pain. Medical record reviet November 27, 2010 "resident continuet (R) hip. Swelling and thighcontacted (obtain results of (R) verbal report of a (R) passed along to one notified6:30 a.m send to ER (emerge (evaluation) and tx (medical services) completed in the continuation of the continuation of the continuation of the x-ray results on November 24, 2010, revealed the result on November 24, 2011, at 8:44 failed to provide follow x-ray results on November 27, 2011 of the x-ray results of x-ray results on November 27, 2011 of the x-ray results of x-ray results on November 27, 2011 of the x-ray results of x-ray resul	w of the a nurse's note dated at 6:00 a.m., revealed do to c/o (complain of) pain @ dispussing remain on (R) mobile imaging provider) to hip x-raytechniclan gave hip fx (fracture) results oming shift. MD (physician) received v/o (verbal order) to noty room) for evalureatment). EMS (emergency entacted for transport" W of the x-ray report dated at 11:11 a.m., revealed at a deformity of the right greatment of the injury is continued medical record from the facility and the facility of the facility on the facility and obtain the the facility wed up and obtain the the facility when the resident	F 281		DEFICIENCY			
	fracture of three days							

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ON NUMBER: A. BUILDING		SOMMETING DECEMBER AND STATE OF THE SECOND STA	(X3) DATE SURVEY	
			445291	B. WI	1G_		05/	11/2011
100200000000000000000000000000000000000	PROVIDER OR SUPPLIER	R			1	REET ADDRESS, CITY, STATE, ZIP COD 100 STALLING LANE ERWIN, TN 37650	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	A resident who is ur daily living receives maintain good nutrit and oral hygiene. This REQUIREMEN by: Based on medical rand interview, the facare was provided for residents reviewed. The findings include Resident #3 was additional record reviews of Colon Carr Disorder, Hypertensi Medical record reviews of the dated May 3, 20 had short and long-teseverely impaired detotally dependent on daily living); and had Medical record reviewdated October 8, 200 tube60 cc (cubic cellected Medical record reviews february 8, 2011, reviews sesist with ADL functions.	DEI ablithe de concilité on de concilité de	e to carry out activities of necessary services to grooming, and personal s not met as evidenced or review, observation of failed to ensure mouth the (#3) of twenty-eight ed to the facility on iagnoses including with Resection, Bipolar and Chronic Constipation. If the MDS (Minimum Data revealed the resident memory problems and con-making skills; was if for ADLs (activities of seeding tube. In a physician's order evealed "Jevity 1.5 per meters) / hr (hour)" The care plan updated ed "Requires totalAssist with oral care at	F	312		y thereafter ire a tube daily basis. Iministration will be lade when ortance of ident on cted by the /26/11 for /26/11 for /23/2011 latity he facility he facility neleted daily c next four ladit will Committee rance linistrator, larmacist, or, Rehab I QA Nurse, dentified,	6/20
	least twice qd (every							

	NT OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILD)	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY
			445291	B. WING		0.5/	11/2011
	PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, Z 100 STALLING LANE ERWIN, TN 37650		1112011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
SS=E	needed)Set up su mouth/teeth at mini Observation on May revealed the resider bedside. Continued mouth and lips were coated with a white 9, 2011, at 12:30 p.r. confirmed the mouth observation and into 12:40 p.m., with LPN #1 confirmed the mot tongue was coated with resident was in r 483.60(a),(b) PHARI ACCURATE PROCE The facility must providings and biologicals them under an agree §483.75(h) of this paunicensed personne law permits, but only supervision of a licen A facility must provide including procedures acquiring, receiving, cadministering of all drine needs of each resident was empty.	pplic mun 9, 2 nt in lobs dryssubsem, vide subsem, vide subsem. Vide is to i merrt. I to a und sed ugs iden loy of whom one in the control of the control	es and cueto clean of 2 x (times) daily" 2011, at 12:30 p.m., a geri-chair at the servation revealed the and the tongue was stance. Interview on May with the resident d lips were dry. W on May 9, 2011, at censed Practical Nurse) and lips were dry; the a white substance and of mouth care. EUTICAL SVC - RES, RPH routine and emergency the residents, or obtain the facility may permit administer drugs if State er the general nurse. armaceutical services the assure the accurate ensing, and and biologicals) to meet at: or obtain the services of provides consultation	F 312	Residents- All medications for 4,5,8,9,10,21,12, and 26 are be by either a Registered Nurse Practical Nurse. All residents in the facility will administrate red by a Register Licensed Practical Nurse. Policies and Procedures relatinurses will be reviewed on 5/2 made if appropriate. All nurse's license will be reviewed on the DON to verify all nurses on licensed in the State of Tenness allows and the State of Tenness of the DON to verify all nurses and licensed in the State of Tenness of the DON to verify all nurses and licensed in the State of Tenness of the DON to verify all nurses of licensed in the State of Tenness of the DON to verify all nurses of licensed in the State of Tenness of DON to verify all nurses of licensed in the State of Tenness of DON to verify all nurses of licensed in the State of Tenness of DON to verify all nurses of licensed in the State of Tenness of Inc. Nurse of Don the State of Tenness of Inc. Nurse of Inc. N	eing administrated or Licensed If have medications red Nurse or a on to hiring of 0/11 with revisions ewed by 5/26/11 by re currently see. e presented to the asis. The Quality s include the cor, Pharmacist, rdinator, Rehabor, and QA Nurse. Is are identified.	6/20

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	E SURVEY
			445291	B. WING _		_{0:}	5/11/2011
	PROVIDER OR SUPPLIER	ER		10	EET ADDRESS, CITY, S 10 STALLING LANE RWIN, TN 37650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	YMUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 42	5 Continued From pa	age 7	e e	F 425			
	by: Based on medical review of facility na review and interview medications were a in accordance with for eight (#4, #5, #8 twenty-eight resider The findings include Resident #4 was ad 28, 2010, with diagn Schizophrenia, Hype Pulmonary Disease, Hypothyroidism, Hes Seizures and Anemi Medical record revier recapitulation orders revealed " Clonaze (by mouth) TID (three " Hydrocodone 5/5 Medical record revier revealed the following administered by an undoses of Clonazepandose on January 19 administery 27, and two	recotice w, the definition of the control of the co	d to the facility on May including Dementia, sion, Chronic Obstructive coarthrosis, Loss, Pneumonia, the physician's d January 1-31, 2011, 0.5 mg (milligrams) PO es a day)" and O BID (twice a day)" the narcotic records dications were nsed employee: two mg on January 13, one 0, two doses on s on February 2, 2011, ng-one dose on January 2 and 3, 2011.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONS	TRUCTION	(X3) DATE	SURVEY PLETED
		}	445291	B. WI	IG		05	/11/2011
	PROVIDER OR SUPPLIER	≣R			STREET ADDR 100 STALLI ERWIN, TI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI YAG	X (E/	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH \$S-REFERENCED TO THE API DEPICIENCY)	IOULD BE	(X5) COMPLETION DATE
	Administration Reco 2011, and February unlicensed employer resident's regularly January 13, 19, 20, and 3, 2011. Resident #5 was ad 21, 2010, with diagr Gastrointestinal Ble Cancer, Insomnia, In Depression, Chronic Disease, Constipation Medical record review recapitulation orders revealed, Morphine and Oxycodone 7.5/ needed. Medical record review revealed the following administered by an undose of Morphine 45 and February 2 and 20 Oxycodone 7.5/325 of Oxycodone 7.5/325 of Oxycodone 7.5/325 and 27 and February Medical record of the 2011, and February unlicensed employeemedical resident's regularly subjunting 13, 19, 20 and 3, 2011. Resident #8 was administer #8 was ad	mitteed, (control of the control of	dated January 1-31, 8, 2011, revealed the so administered the eduled medications on 27 and on February 2 ed to the facility on June s including Osteoporosis, Breast entension, Gastritis, estructive Pulmonary Anemia and Constipation. If physician's ted January 1-31, 2011, and PO every twelve hours are every four hours as fithe narcotic record edication was ensed employee; one on January 13 and 27 on January 13; one dose g on January 13; one dose g on January 19, 20, 24 2011. AR dated January 1-31, 2011, revealed the oradministered the duled medications on 7 and on February 2 and dito the facility on	F 4	25			
	and Oxycodone 7.5/ needed. Medical record revie revealed the followin administered by an u dose of Morphine 45 and February 2 and 3 Oxycodone 7.5/325 of Oxycodone 7.5/32 and 27 and February Medical record of the 2011, and February 1 unlicensed employee resident's regularly so January 13, 19, 20 at 3, 2011.	w of g municipal manufactures of the conditions	the narcotic record edication was ensed employee; one on January 13 and 27 2011; two doses of on January 13; one dose g on January 19, 20, 24 2011. AR dated January 1-31, 2011, revealed the oradministered the duled medications on 7 and on February 2 and d to the facility on					

10	~		E W INEBIOAID OLIVIOLE				OMB M	<i>J.</i> 0938- <u>0</u> 391	
A	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	MULTIPLE CONS IILDING	TRUCTION	(X3) DATE SURVEY COMPLETED		
L			445291	B. WI	NG		05/	11/2011	
		PROVIDER OR SUPPLIER HEALTH CARE CENT			STREET ADDR 100 STALL ERWIN, T	100000000000000000000000000000000000000			
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			CIX (E.	PROVIDER'S PLAN OF CORE ACH CORRECTIVE ACTION S SS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
		Depression, Osteoral Infection, Diabetes History of Deep Veil Medical record review recapitulation orders revealed, Lorazeparneeded and Clonaze Medical record review revealed the following administered by an edose of Clonazeparnend 27 and one dose January 19 and 24, 2011, revealed the unadministered the resmedications on January Resident #9 was administered the resmedication, Major Deprember 14, 2007, Coronary Artery Dise Failure, Hypertension Agitation, Major Deprember Medical record review recapitulation orders revealed, Hydrocodor hours as needed and day. Medical record review revealed the following administered by an unadministered by an unadminis	arthritis, Suicidal, Urinary T Mellitus, Morbid Obesity, a in Thrombosls. ew of the physician's a dated January 1-31, 2017 m 0.5 mg every six hours a repam 0.25 mg twice daily. ew of the narcotic records and medicalion was unlicensed employee: one on 0.5 mg on January 19, 24 are of Lorazepam 0.5 mg on 2011. e MAR dated January 1-31 unlicensed employee also sident's regularly scheduled uary 19, 24 and 27, 2011. mitted to the facility on with diagnoses including ease, Congestive Heart on, Schizoaffective Disorder ression, Anxiety, Diabetes on's Disease. w of the physician's dated January 1-31, 2011, ne 5/500 mg every four it Alprazolam 0.5 mg every w of the narcotic record	ract and	425				

PRINTED: 05/13/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 445291 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 STALLING LANE **ERWIN HEALTH CARE CENTER** ERWIN, TN 37650 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 10 F 425 24, and February 3, 2011, and one dose of Hydrocodone 5/500 mg on January 20, 2011. Medical record of the MAR dated January 1-31, 2011, and February 1-28, 2011, revealed the unlicensed employee also administered the resident's regularly scheduled medications on January 13, 20, 24 and on February 3, 2011. Resident #10 was admitted to the facility on March 15, 2010, with diagnoses including Gastroenteritis, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Hypertension, History of Colon Cancer, Colostomy, Spinal Stenosis and Chronic Back Pain. Medical record review of the physician's recapitulation orders dated January 1-31, 2011, revealed Lortab 5 mg every six hours as needed and Ativan (Lorazepam) 0.5 mg twice daily. Medical record review of the narcotic records revealed the following medication was administered by an unlicensed employee of the facility: two doses of Lortab 5 mg on January 13 and one dose on January 20 and 27, 2011, and one dose of Lorazepam 0.5 mg on January 13, 20 and 24, 2011. Medical record of the MAR dated January 1-31, 2011, revealed the unlicensed employee also administered the resident's regularly scheduled medications on January 13, 20, 24 and 27, 2011. Resident #11 was admitted to the facility on May 3, 2010, with diagnoses including Iron Deficiency

Anemia, Hypertension, Arteriosclerotic Heart Disease, Syncope, Osteoarthritis, Osteopenia.

PRINTED: 05/13/2011

DEPAR CENTE	RTMENT OF HEALT RS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 05/13/20 FORM APPROVI
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		445291	B. WING _		05/11/2011
	PROVIDER OR SUPPLIER	TER	10	EET ADDRESS, CITY, STATE, Z 00 STALLING LANE RWIN, TN 37650	05/11/2011 IP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DATE
F E C M	Dementia, Gastroir Anxiety, Chronic A Medical record revirecapitulation order revealed Alprazolar as needed, 0.5 mg daily (2:00 p.m.). Medical record revirevealed the following administered by an facility: one dose of January 19 and 20:0.5 mg on January 19 and Coronary Artery Medical record reviewed and Coronary Artery Medical record reviewed and Alprazolary 19 and Coronary Artery Medical record reviewed 19 and 20	ntestinal Reflux Disease, rthralgia and Left Hip Fracture iew of the physician's rs dated January 1-31, 2011, m (Xanax) 0. 25 mg twice dail at 8:00 a.m., and 0.25 mg ew of the narcotic records ing medication was unlicensed employee of the Alprazolam 0.25 mg on and one dose of Alprazolam 20 and 27, 2011. The MAR dated January 1-31, unlicensed employee also sident's regularly scheduled uary 19, 20, and 27, 2011. Idmitted to the facility on July ises including Aspiration Renal Failure, Pleural ion, History of Stroke, lux Disease, Diabetes expression, Anxiety, Dementia Disease. W of the physician's dated January 1-31, 2011, no 5 mg every six hours as am 0.5 mg three times a			
re	evealed the following	w of the narcotic records g medication was	1 88		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONS	(X3)	(X3) DATE SURVEY COMPLETED			
			445291	8. Wit	NG	,		05/	11/2011	
	F PROVIDER OR SUPPLIER	ER.			STREET ADDR 100 STALLI ERWIN, TI		IP GODE	00,		*
(X4) ID PREFIX TAG	((EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	X (E/	PROVIDER'S PLAN O ACH CORRECTIVE AC SS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRIA	E ATE	(X5) COMPLETION DAYE	ч
F 42	facility: one dose of January 24, 2011; or mg on January 13 a 0.5 mg on January and 3, 2011. Medical record of the 2011, and February unlicensed employer resident's regularly some January 13, 19, 20, 2 and 3, 2011. Resident #26 was ac 12, 2010, with diagnoral Thrive, Gastrointestin Artery Disease, Schiz Chronic Obstructive In Arteriosclerotic Cardia Alzheimer's Disease. Medical record review recapitulation orders revealed Lorazepam Medical record review revealed the following administered by an unfacility: one dose Lora 24, 2011. Medical record of the 2011, revealed the unadministered the residemedications on Januar Review of the unlicens	Hydrone Condition of the Condition of th	rocodone 5 mg on dose of Alprazolam 0.5 wo doses of Alprazolam 0.5 wo doses of Alprazolam 20, 24, 27 and February 2 AR dated January 1-31, 3, 2011, revealed the so administered the duled medications on and 27 and on February 2 fied to the facility on July including Failure to Reflux Disease, Coronary brenia, Dementia, monary Disease, scular Disease and the physician's ad January 1-31, 2011, mg twice daily. The narcotic records dication was used employee of the am 0.5 mg on January 1-31, used employee also is regularly scheduled 4, 2011.	,	25					
	medications on Janua	ry 2. ed e	4, 2011.							

STATEMENT OF DEFICIENCIES (X/		(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	n Massacana	IÙLTIPLE CONS LDING	TRUCTION	(X3) DATE	SURVEY
			445291	B. WI	NG		05.	/11/2011
1	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER			STREET ADDR 100 STALL ERWIN, T			
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	Registered Nurse p was employed by the and was not licensed 10, 2011. Review of the facility Administration reversity approved by the state the responsibility for and recording of me access to drug storastation. 3. Only licensed to pass must be responsibility for and recording of me access to drug storastation. 3. Only licensed to pass must be responsible to pass must be responsible to pass must be recorded to pass must be recorded to pass must be recorded to pass and the time were administered or from the RN program employed by the facility passed medications license until February interview with the RN administered regular meeded) medications medication pass for the recorded to the recorded to the recorded to the recorded to the RN administered regular meeded) medications medication pass for the recorded to the reco	y's paled as y's paled to reduce the present of the	am in December 2010; cility on January 7, 2011; a nurse until February colicy for Medication, "2. Only personnel egulations are assigned paring, administering, ations, or permitted areas at each nursing personnel shall be ations" colicy for controlled controlled drugs in V are subject to special cal, and record keeping. Cessible only to ing and pharmacy of Nursing and the re responsible for the May 9, 2011, at 9:00 tered Nurse) who was a medications above med the RN graduated December 2010; was an January 7, 2011; and the facility without a 2011. Continued affirmed the RN heduled and PRN (as the residents during the	F	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE:		
			445291	B. WING		_05/	11/2011
	PROVIDER OR SUPPLIER	R			REET ADDRESS, CITY, STATE, ZIP CO 100 STALLING LANE ERWIN, TN 37650	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	resident #4, #5, #8, and interview on Ma with the DON (Direct conference room, or employee graduated December 2010; was January 7, 2011; an medications as note #8, #9, #10, #11, #1 regularly scheduled during the medication dates. Continued in confirmed the emplo RN until February 10	#9, y 10 tor or o	#10, #11, #12, and #26 0, 2011, at 10:10 a.m., of Nursing), in the med the unlicensed m an RN program in mployed by the facility on iministered each of the bove for residents #4, #5, and #26 and administered dications to the residents asses for the above liew with the DON was not licensed as an 111.	F 425			6/20
	a licensed pharmacis of records of receipt controlled drugs in staccurate reconciliation records are in order accurated drugs is mareconciled. Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Safacility must store all accordance accessors.	oloyst what and affice and affice and affice and affice who are a windown as a war and affice and affice af	& BIOLOGICALS or obtain the services of the establishes a system disposition of all lent detail to enable an and determines that drug that an account of all ained and periodically led in the facility must be the currently accepted and include the ad cautionary ration date when	F 431	Resident # 26- when any narcotic me any portion of a narcotic medication administered to resident # 26, Two linurses will sign the narcotic log when narcotic is waster. All residents who have any narcotic nor any portion of a narcotic medicati administered and must be wasted will ilcensed nurses sign the narcotic log. Policies and Procedures relating to wasted will be reviewed with revisions made if appropriate. In In-service will be completed on 5/2 DON for all RN's and LPN's on the pprocedure regarding the wasting of needications. An in-service will be helf or those who were unable to attend of An audit will be completed by the Qu Assurance Nurse on a daily basis for the weeks beginning 5/23/11, then a mining residents will be reviewed weekly for and monthly thereafter.	is not censed in the medication on not l have tow asting l on 5/20/11 3/11 by the olicy and arcotle d on 5/26/11 on 5/23/11 allty we residents' c first two num of five	

STATEMENT OF DEFIGIENCIES AND PLAN OF CORRECTION		(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	R			1	REET ADDR 100 STALL ERWIN, T			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION)	PREI TAI	IX		PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
	controls, and permit have access to the The facility must propermanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distrik quantity stored is mit be readily detected. This REQUIREMEN by: Based on medical review and interview two nurses witnesses substance for one (#reviewed.) The findings included Resident #26 was acted 12, 2010, with diagnoral Thrive, Gastrointestin Artery Disease, Schiz Chronic Obstructive Arteriosclerotic Cardialzheimer's Disease. Medical record review	onlikey: vide corred in g A and the buttonim This economic thickey: limit become the corresponding the corresponding the corresponding the corresponding to	y authorized personnel to s. e separately locked, inpartments for storage of a Schedule II of the buse Prevention and other drugs subject to a facility uses single unit on systems in which the hall and a missing dose can be facility failed to ensure a wasting of a controlled of twenty-eight residents ted to the facility on July including Failure to Reflux Disease, Coronary incenia, Dementia, monary Disease, iscular Disease and the physician's ed January 1-31, 2011, mg twice daily.		431	on a mor Committ Assistant Administ Registere Director, When ar	trator, Medical Director, Pharm d Dietitian, MDS Coordinator, Social Service Director, and Q cas of focus and trends are ider ans will be developed and follow	nce Istrator, nacist, Rehab A Nurse itilied,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			445291	B. WI	NG_	2 - 46		05/	11/2011
ERWIN	PROVIDER OR SUPPLIER				10	ET ADDRI O STALLII RWIN, TN	Propose a substantial of		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PREF TAG		(EA	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	revealed Lorazapar medication) 0.5 mg and 25, 2011. Confirecord revealed only signed for the waste 2011, and only one wasted medication of Review of the facility medications reveale from the container form the container for the documented on the line representations on the line representations on May 10, Director of Nursing, it confirmed the facility sign for wasted Schemedications was not	n (So was inue to the doministic or ad doministic or ad to giv and to giv and and to giv and to giv and to giv and to giv and to giv and to gi	chedule IV controlled wasted on January 24 d review of the narcotic unlicensed employee edication on January 24, sed nurse signed for the anuary 25, 2011. Dicy for controlled .If a dose is removed ministration, but refused en for any reason, it is to arcotic Inventory Record hat dose by two (2) the narcotic record and 1, at 10:10 a.m., with the conference room licy for two nurses to IV controlled		431				
	SPREAD, LINENS The facility must esta Infection Control Prografe, sanitary and cort to help prevent the de of disease and infection Control F The facility must estal Program under which	blish gram nfort velo on. rogr blish it -	and maintain an designed to provide a able environment and pment and transmission	F 44	i i i i i i i i i i i i i i i i i i i	changed on appropriate All resident hat care pure the confection confection confection and elf appropriate the confection of the confectio	1- resident # 1 has their dressing 5/21/11 by the wound care nur e procedure was followed. Is who require wound care will covided following appropriate introl guidelines. I procedures relation to wound tweed on 5/20/11 with revisions in roprinte. I will be completed on 5/23/11 RN's and LPN's on the procedures will be or those who are unable to attentions who are unable to attentions.	have care being by the ure e held	6/20

STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) (A. BU		FIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED	1
			445291	B. WI	NG_		1 0	5/11/2011	
	PROVIDER OR SUPPLIER HEALTH CARE CENTI	ER			1	REET ADDRESS, CITY, STATE, ZIP COI 100 STALLING LANE ERWIN, TN 37650		0/1/1/2011	
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F 441	(2) Decides what pr should be applied to (3) Maintains a reco actions related to in	an rd c	dures, such as isolation, individual resident; and f incidents and corrective ons.		141	Assurance Nurse. One dressing char wound care nurse will be observed e the first two weeks, then weekly for then monthly thereafter. The audits 5/23/11. The audit will be reviewed by the OA	nge by the each day for one month, will begin on		
	isolate the resident. (2) The facility must communicable disea from direct contact v direct contact will tra (3) The facility must	on (side of in prolesse of in proles	Control Program ent needs isolation to fection, the facility must hibit employees with a for infected skin lesions residents or their food, if hit the disease. hire staff to wash their resident contact for which d by accepted			on a monthly basis. The Quality Assis Committee members include the Adr Assistant to the Administrator, Medical Director, Ph Registered Dietilian, MDS Coordinat Director, Social Service Director, and When areas of focus and trends are is action plans will be developed and fobe completed.	urance ninistrator, armacist, tor, Rebab J QA Nurse. dentified		
	failed to implement ha	cord r, ar and ted : nfed res rev	review, observation, and interview, the facility hygiene practices standards of practice, to ctions and cross ident (#1) of						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/13/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 445291 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 STALLING LANE **ERWIN HEALTH CARE CENTER** ERWIN, TN 37650 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 17 Audits will be completed by the Quality F 441 Assurance Nurse. One dressing change by the (2) Decides what procedures, such as isolation, wound care nurse will be observed each day for should be applied to an individual resident; and the first two weeks, then weekly for one month, (3) Maintains a record of incidents and corrective then monthly thereafter. The audits will begin on actions related to infections. 5/23/11. The audit will be reviewed by the QA Committee (b) Preventing Spread of Infection on a monthly basis. The Quality Assurance (1) When the Infection Control Program Committee members include the Administrator, determines that a resident needs isolation to Assistant to the Administrator, Medical Director, Pharmacist. prevent the spread of infection, the facility must Registered Dietitian, MDS Coordinator, Rehab isolate the resident. Director, Social Service Director, and QA Nurse, (2) The facility must prohibit employees with a When areas of facus and trends are identified, communicable disease or infected skin lesions action plans will be developed and follow up will be completed. from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

(c) Linens

professional practice.

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, review of facility policy, and interview, the facility failed to implement hand hygiene practices consistent with accepted standards of practice, to reduce the spread of infections and cross contamination for one resident (#1) of twenty-eight residents reviewed.

The findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. GUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY		
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70.00.000.000.000.000.000	PROVIDER OR SUPPLIER	ER	10	EET ADDRESS, CITY, STATE, ZII 00 STALLING LANE RWIN, TN 37650	CODE	a d	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Resident #1 was ad 24, 2010, with diagr Repair, Schizophrer Disease, and Glauc Observation during 2011, at 10:00 a.m., revealed the resider containing yellow exhip. Continued obse (Registered Nurse): hands, cleaned the applied the prescribe with a gloved finger, clean dressings with washing hands. Review of the facility Handwashing" reveath changed after having material (wound drain interview with R.N. #p.m., on the patio, cowashed and the glov	mitted to the facility on June closes including Fractured Hip hia, Dysphagia, Parkinson's oma. In dressing change on May 10, in the resident's room at in bed with an open wound udate in the base, on the left ervation revealed R.N. If I washed and gloved the wound with wound cleanser, and dressed the wound with out changing the gloves and policy "Gloves and led"gloves should be grontact with infected nage)." I on May 10, 2011, at 12:30 onfirmed the hands were not es were not changed bleaning and the application	F 441				